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	175160	A. BUILDING _____ B. WING _____	R 06/04/2012

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{F 000}	INITIAL COMMENTS The following citations represent the findings of a non-compliance revisit and complaint investigations #KS00056402, #KS0006403 and #KS00056662.	{F 000}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 117 residents. The sample included 9 residents. Based on observation, record review and interview, the facility failed to prevent the development of a stage two pressure sore for one of three sampled residents (#2007) with a history of pressure sores. Findings included: - The May Physicians Order Sheet (POS) recorded resident #2007 admitted to the facility on 5/22/12. The initial nursing data assessment for the readmission on 5/22/12 documented the resident as alert and oriented to person, place and time,	{F 314}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{F 314}	Continued From page 1	{F 314}		

with some short term memory problems. The data sheet recorded the resident required extensive assistance of one to two staff members with most activities of daily living. This same assessment recorded the resident in bed most of the time and received total parenteral nutrition (TPN). The assessment further documented the resident was incontinent of stool, with an indwelling Foley catheter and admitted with a Mepilex border on his/her coccyx.

According to the manufacture, Molnlycke Health Care: Mepilex Border is an all-in-one foam dressing that effectively absorbs and retains exudate, maintains a moist wound environment, and minimizes pain and trauma at dressing changes. This wound dressing is used in a variety of wound treatments which includes pressure ulcers.

The resident's initial (readmission) care plan dated 5/22/12 directed staff to: follow the skin care protocol, turn every 2 hours, and immediately report any redness or skin breakdown to the charge nurse. This same care plan lacked documentation of the resident's potential for developing pressure sores and/or presence of, or treatment for any current pressure sores.

Review of the re-admission nurse's progress note dated 5/22/12 timed 6:45 P.M. revealed: the resident arrived at the facility with a Mepilex border cover on his/her coccyx, with pink surrounding skin but {nurse} unable to find an open area.

The weekly wound skin assessment dated

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{F 314}	Continued From page 2 5/23/12 also lacked documentation of the resident's coccyx wound. Review of the Braden Scale (a numerical scale used to determine pressure sore potential) dated 5/22/12 revealed a score of 15 which indicated the resident was at risk for development of pressure ulcers. According to the Center for Medicare and Medicaid Services MDS Assessment Instrument User's Manual, revised May 2011: Stage I pressure ulcer = "An observable pressure related alteration of intact skin whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following: ...a defined area of persistent redness in lightly pigmented skin..." Stage II pressure ulcer= "Partial thickness loss of the dermis presenting as a shallow open ulcer with a red pink wound bed without slough." On 5/29/12 between 2:30 P.M. and 3:00 P.M. during catheter and perineal care, observation revealed the resident with an excoriated bottom and 3 small circular dark reddened areas on his/her lower right buttock near the gluteal fold. Also noted on the resident's right buttock was a small amount of blood from an open area (appeared as an abrasion) measuring approximately 2 mm (millimeters) by 3 to 4 mm. Continued observation revealed an approximately 1 cm (centimeter) by 1 cm open area on the resident's coccyx. On 5/29/12 at 2:45 P.M. licensed nursing staff E stated, "We received a new order for that this afternoon." (Referring to the pressure ulcer	{F 314}		

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{F 314}	Continued From page 3 treatment orders) On 5/29/12 at 3:00 P.M. the resident laid on his/her right side following catheter care. The resident complained of pain and said, "Thanks for getting me off of my butt, that was burning like fire." On 5/29/12 at 3:05 P.M. licensed nursing staff J applied normal saline to the resident's wound(s) patted the areas dry with gauze patches and attempted to measure the wounds (subsequent record review revealed no measurements recorded). Licensed nurse J then applied an Allevyn foam dressing and secured with cloth tape. On 5/29/12 at 3:30 P.M. review of the physician's telephone orders revealed an unsigned physician's telephone order dated 5/29/12 timed 1:00 P.M. for Allevyn foam to the resident's buttocks (not observed during initial record review). Change every shift. On 5/29/12 at 3:30 P.M. licensed nursing staff I acknowledged he/she received the order at 1:00 P.M. on 5/29/12 but did not have time to transcribe it to the TAR or apply the dressing to the resident. Review of the nurse's progress notes on 5/30/12 at 8:20 A.M. revealed the most recent entry was on 5/28/12 at 9:30 P.M. and lacked documentation of the new order for the Allevyn foam, change of dressing, size of the resident's open area and area of redness. On 5/31/12 at 8:30 A.M., licensed nursing staff D	{F 314}		

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{F 314}	Continued From page 4	{F 314}		

stated, "We have not been able to find the measurements from the resident's wound done on 5/29/12. I think he/she {nurse} might have just written them on a sheet of scratch paper and then onto the nurse's notes but I cannot find a nurse's note." Administrative nurse D added that wound measurements were done on Wednesdays by the wound care nurse.

On 5/30/19 at 1:50 P.M. licensed nursing staff D explained, the resident originally admitted on 3/2/12 with a stage 3 pressure ulcer to his/her coccyx and the facility healed it. He/she went out to the hospital on 4/25/12 and came back on 5/22/12 and had Mepilex over the wound and when staff removed the dressing, no wound was present, but we cannot say it was healed because once a person has a stage 3 pressure ulcer it is considered a stage 3 for at least a year. I was not really tracking it after 5/22/12 because there was not anything there to track, and then yesterday we found it was an open area and I measured it. Licensed nursing staff D stated that he/she kept wound documentation in a separate binder.

Continued record review of the nurses progress notes on 5/30/12 at 2:00 P.M. revealed an entry by licensed nursing staff D dated 5/30/12 and timed 7:00 A.M. (this entry not present when record reviewed on 5/30/12 at 8:20 A.M.), "wound on resident's coccyx noted to be 1 cm (centimeter) by 0.5 cm by 1 cm, wound bed with drainage, peri-wound pink. Continue foam dressing and change every day. Air mattress ordered ..."

The facility policy titled Assessment and documentation of Wounds dated 3/12 directed

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{F 314}	Continued From page 5 staff to provide accurate assessment and documentation of wounds and wound status, these were vitally important in management of wounds and instructed staff to document the location of the pressure ulcer and accurate measurements of a wound was essential for assessing progress in healing a wound. On 5/29/12 at 1:30 P.M. administrative nursing staff B stated, "wound care should have been noted on the treatment assessment record right away; I can tell we need to do some staff education." The clinical record lacked evidence the development of the pressure ulcer was unavoidable for this resident with a history of pressure sores. The facility failed to complete timely assessments of the pressure sore.	{F 314}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 117 residents. The sample included 9 residents. Based on	{F 315}		

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observation, record review and interview, the facility failed to address cares for 1 of 3 sampled residents with an indwelling Foley catheter (#2007).

Findings included:

- The May 2012 physician's order sheet (POS) recorded resident #2007 admitted to the facility on 5/22/12.

The initial nursing data assessment dated 5/22/12 documented the resident was alert and oriented to person, place and time, with some short term and long term memory problems. The data sheet recorded the resident required extensive assistance of one to two staff members with most activities of daily living. This same assessment recorded the resident was incontinent of stool and with an indwelling urinary Foley catheter.

The clinical record lacked medical justification for the catheter.

Review of the resident's initial care plan dated 5/22/12 recorded a single intervention for the resident's Foley, "catheter care per facility policy."

Continued review of the POS revealed physician's orders dated 5/27/12 (5 days after admission) which directed staff to provide Foley catheter care every shift, and to change the Foley catheter every month on the 2nd shift.

During an interview on 5/29/12 at 2:00 P.M. the resident stated, "staff empty [his/her] catheter drainage bag almost every time they are in here

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{F 315}	Continued From page 7 and it needs to be dumped most of the time." On 5/31/12 at 8:30 A.M. licensed nursing staff E acknowledged the resident's catheter orders were not transcribed until 5 days after admission and stated "to be perfectly honest there is no reason for that; I think the night shift caught it [the oversight] called the physician and obtained the orders." On 5/30/12 at 1:30 P.M. administrative nursing staff B stated, the person that noticed it called the physician and obtained the orders and then wrote the orders. The facility's policy titled catheter care dated 3/12 lacked any specific direction for obtaining physician orders, care of, or documentation for residents with an indwelling catheter. The facility failed to obtain a physician's order and medical justification for the resident's indwelling Foley catheter.	{F 315}		
{F 323} SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 117 residents	{F 323}		

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and the sample included 9 residents. Based on observation, record review and interview, the facility failed to implement timely interventions to prevent accidents for 1 of 3 residents sampled for accidents (#2008) which resulted in a fall that required 4 sutures in the Emergency Room (ER).

Findings included:

- Resident #2008 admitted to the facility on 4-7-12. The resident's April 2012 Physician's Order Sheet (POS) recorded diagnoses of hypertension (elevated blood pressure) and pain in limb. The POS recorded orders dated 4-7-12 for Clonidine HCL 0.1 milligrams (mg) tab by mouth every 6 hours as needed if systolic blood pressure was over 170; Atenolol 25 mg one tab daily; Diltiazem 240 mg cap daily and Cozaar 50 mg one tab daily (all medications for hypertension).

The discharge form from a local hospital dated 4-7-12 recorded the resident required fall precautions.

The physician's order dated 4-13-12 documented staff scheduled the resident an appointment with a cardiologist to address hypertension, orthostatic blood pressures for 3 days and to discontinue Cozaar per patient request.

The 5 day Minimum Data Set (MDS) dated 4-14-12 recorded the resident with a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS recorded the resident required limited assistance with bed mobility, transfers, walking in room or corridor, locomotion on or off unit, dressing, toilet

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use, and personal hygiene. The resident used a walker and wheelchair for mobility. The resident was always continent of bowel and bladder. The resident did not have a fall during the month before admission, or 2-6 months before admission.

The admission/readmission data collection and initial plan of care dated 4-7-12 recorded the resident was alert and oriented to person, place and time, was continent of bowel and bladder, required set up assistance with bed mobility, assist of 1 staff with transfers, walking in his/her room, hallway, dressing, toileting, and personal hygiene. The resident did not have a history of falls, was not inconsistent in understanding his/her limitations, and was not cognitively impaired.

Nurse's note dated 4-7-12 at 7:00 P.M. recorded staff admitted the patient at 3:50 P.M. The resident was alert and oriented to person, place and time with episodes of forgetfulness.

Nurse's note dated 4-8-12 at 1:30 P.M. recorded the resident could walk independently in his/her room and went to the bathroom on his/her own.

Nurse's note dated 4-9-12 no time recorded, documented the resident ambulated with an unsteady gait. At 12:00 A.M. the resident was independent with Activities of Daily Living (ADLs).

Nurse's note dated 4-11-12 at 9:00 A.M. recorded the resident had dizziness walking to the bathroom. His/her blood pressure was 100/40 and staff held the resident's blood pressure medication.

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The Nurse's notes dated 4-11-12 at 9:00 A.M. recorded staff went to give the resident his/her morning medications and the resident complained of dizziness with low blood pressure noted. Staff held the resident's blood pressure medications per nursing judgment and educated the patient to not walk by him/herself. At 9:45 A.M. two staff assisted the resident to the bathroom and he/she stated the dizziness decreased. At 12:00 P.M. staff was walking the resident to bathroom and his/her "legs were giving out". The resident's blood pressure was 122/51. At 12:15 P.M. the notes recorded the resident required extensive assistance with ADLs and requested the toilet and staff placed the resident's call light within reach.

On 4-12-12 at 3:00 P.M., nurse's note recorded the resident refused his/her 8:00 A.M. blood pressure medications, used a wheelchair to go to the bathroom, and without complaint of dizziness.

Nurse's note dated 4-12-12 documented on the 10 P.M.-6:00 A.M. shift the resident's blood pressure was 100/58.

The Care Track form dated 4-13-12 recorded the resident required 1 staff assist for transfers, bed mobility, and toileting. The resident followed safety instructions and was oriented to person, place and time. The form documented at 8:00 A.M. the resident refused his/her blood pressure medication. At 1:30 P.M. the resident complained of dizziness at times. Staff notified the physician's representative at that time of the resident's dizziness, "blackouts" and refusal for morning blood pressure medications. The resident

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{F 323}	Continued From page 11 required limited assistance with ADLs. Nurse's notes dated 4-14-12, no time recorded, revealed the resident received his/her blood pressure medication in the A.M. and at 11:05 A.M. fell in the bathroom and stated he/she "just blacked out". The resident's blood pressure was 125/63 and the resident received 4 sutures. Nurse's note dated 4-14-12, no time recorded, revealed an order to send the resident to the ER for evaluation. Nurse's note dated 4-14-12, no time recorded, revealed staff initiated a bed and chair alarm for the resident due to a fall. On the admission/readmission data collection and initial plan of care dated 4-7-12 included new interventions dated 4-14-12 which recorded the resident had a fall in the bathroom with laceration to his/her right eyebrow; staff sent the resident to the Emergency Room for sutures; personal alarm and mat to floor put in place to alert staff, and staff started 15 minute checks on the resident. Nurses notes dated 4-15-12 at 7:30 P.M. recorded the resident had a dressing covering the sutures above his/her right eye and the alarm and floor mat were in place. On 5-30-12 at 1:11 P.M., licensed nursing staff E stated from what he/she remembered, the resident required assistance of 1 staff member and required a gait belt. The resident was a little non-compliant at times asking for assist. He/she stated staff initiated the bed and chair alarms on 4-14-12 after the fall. He/she stated the resident	{F 323}		

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appeared alert until you stayed in there for a long period of time. He/she did not think staff realized how confused the resident was at first. Licensed nursing staff E stated he/she honestly did not think there was anything in place for fall prevention before the fall, that the resident was alert enough to use the call light.

On 5-30-12 at 4:25 P.M. licensed nursing staff D stated the resident was pretty independent, toileted independently, and used the wheelchair most of the time. He/she was sure staff encouraged the resident to call for staff assistance after the complaint of dizziness. Licensed nursing staff D acknowledged the resident's complaints of dizziness and legs giving out per the nurses notes. Licensed nursing staff D stated nothing was in place prior to the fall because the resident was independent. He/she acknowledged the fall precautions documented on the hospital transfer sheet.

On 5-31-12 at approximately 8:45 A.M., administrative nursing staff B stated he/she would like to see the staff complete a fall risk assessment upon admission to the facility and stated he/she did not see one for the resident. He/she acknowledged the hospital transfer form documented fall precautions for the resident.

On 5-31-12 at approximately 8:50 A.M. administrative nursing staff C stated that he/she did not see where staff put an alarm on the resident and stated the expectation would be for staff to report changes to the supervisor so they could place interventions for the resident.

The facility failed to implement timely

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{F 323}	Continued From page 13 interventions to prevent falls for this resident, who was assessed to need fall preventions, had complaints of dizziness, lightheadedness, legs giving out and blacking out which resulted in a fall which required 4 sutures in the ER.	{F 323}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility identified a census of 117 residents. Based on observation, interview and record	{F 520}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175160	A. BUILDING _____ B. WING _____	R 06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

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{F 520}	Continued From page 14	{F 520}		

review, the facility failed to have a functioning Quality Assessment and Assurance (QAA) committee to implement plans of action to correct identified deficiencies.

Findings included:

- Based on observation, record review and interview, the facility failed to implement interventions to prevent the development of pressure ulcers. Please see F314 for additional information.

- Based on observation, record review and interview, the facility failed to obtain orders as necessary for a urinary catheter. Please refer to F315 for additional information.

- Based on observation, record review and interview, the facility failed to implement timely fall interventions for a resident at risk for falls. Please refer to F323.

The facility policy dated 3/12 recorded the facility would have an ongoing performance improvement program designed to systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care and resolve identified problems and identify opportunities for improvement.

On 5/31/12 at approximately 10:30 A.M., administrative staff A stated the QAA identified catheters, pressure ulcers and falls as issues and had a plan of action in place.

The facility failed to maintain an effective QAA to

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{F 520}	Continued From page 15 correct identified deficiencies for the residents in the facility.	{F 520}		